Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement for date of service (DOS) 01/09/02?
   b. The request was received on 05/10/02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC-60 and Letter Requesting Dispute Resolution
   b. HCFA
   c. EOB
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. TWCC-60 and Response to a Request for Dispute Resolution
   b. HCFA
   c. Medical Records
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g)(3), the Division forwarded a copy of the requestor's 14-day response to the insurance carrier on 07/31/02. Per Rule 133.307 (g)(4), the carrier representative signed for the copy on 08/01/02. The response from the insurance carrier was received in the Division on 08/08/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Additional Information Submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: letter dated 07/16/02
   "(Provider) performs an anterior extraperitoneal exposure of the spine… We billed our procedure under CPT code 37799 (unlisted vascular) since there was no specific code to reflect his operative contribution in the treatment of disease of the spinal column."

2. Respondent: letter dated 08/08/02

"It is the Carrier's position that in devising the 1996 Medical Fee Guideline, the Commission considered the skills necessary for a surgeon to perform a 'anterior arthrodesis approach' and that the reimbursement provided for under E. Miscellaneous Surgical Issues, 2. Arthrodesis: (d) provides the appropriate reimbursement level for this procedure."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1&2), the only date of service eligible for review is 01/09/02.

2. The Carrier's EOB has the denials: "F – Fee Guideline/Two surgeons with different skill for spearate [sic] specific surgical procedure" & "R – Extent of injury/These services are not reviewable under Workers' Compensation program".

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Code	MAR$	REFERENCE	RATIONALE:
01/09/02	37799-62	$8500.00	$0.00	F, R	DOP	Texas Workers' Compensation Act & Rules, Sec. 408.027 (d), Rules 124.3 (c) & 133.304 (c)	The Carrier's denial does not conform to the requirements of Rule 133.304 (c). The explanation given by the carrier of its denial "F" resembles the definition of the –62 modifier and does not provided adequate explanation to allow the provider the opportunity to justify the billing. The carrier's use of "R" would require the filing of a TWCC-21, per Rule 124.3 (c). A review of the Commission's case file and records finds no such filing by the Carrier. The carrier's response indicates its position is that the service in dispute is an anterior arthrodesis approach and not anterior extraperitoneal exposure. The operative report states, "With sharp and blunt dissection, the rectus muscle was moved laterally and the posterior rectus sheath was incised in a vertical direction to expose the preperitoneal space and was then entered. The abdominal contents were moved medially and the peritoneum was freed from its retroperitoneal attachments." The medical documentation indicates the service provided was properly billed. Therefore, provider is entitled to the $6,861.67 requested on the TWCC-60.

01/09/02	37799-51 37799-51	$3500.00 $3500.00	$0.00 $0.00	R R	DOP	Texas Workers' Compensation Act & Rules, Sec. 408.027 (d), Rules 124.3 (c) & 133.304 (c)	The Carrier's denial does not conform to the requirements of Rule 133.304 (c). The carrier's use of "R" would require the filing of a TWCC-21, per Rule 124.3 (c). A review of the Commission's case file and records finds no such fining by the Carrier. The carrier's response indicates its position is that the service in dispute is an anterior arthrodesis approach and not anterior extraperitoneal exposure. The operative report states, "With sharp and blunt dissection, the rectus muscle was moved laterally and the posterior rectus sheath was incised in a vertical direction to expose the preperitoneal space and was then entered. The abdominal contents were moved medially and the peritoneum was freed from its retroperitoneal attachments." The medical documentation indicates the service provided was properly billed. Therefore, provider is entitled to the **$4,400.00** ($2,200.00 x 2) requested on the TWCC-60.
Totals		$15,500.00					The Requestor is entitled to reimbursement in the amount of $11,261.67.

The above Findings and Decision are hereby issued this 25th day of October 2002.

Larry Beckham
Medical Dispute Resolution Officer
Medical Review Division

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $11,261.67 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 25th day of October 2002.

David Martinez
Medical Dispute Resolution Manager
Medical Review Division

DM/lb